

(1) Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians;

(2) Identify the state legal authority permitting such objection; and

(3) Describe the range of medical conditions or procedures affected by the conscience objection.

(ii) Provide the information specified in paragraphs (d)(1)(i) of this section to each enrollee at the time of initial enrollment. If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the HMO or CMP may give advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accordance with State law. The HMO or CMP is not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.

(iii) Document in the individual's medical record whether or not the individual has executed an advance directive;

(iv) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(v) Ensure compliance with requirements of State law (whether statutory or recognized by the courts of the State) regarding advance directives;

(vi) Provide for education of staff concerning its policies and procedures on advance directives; and

(vii) Provide for community education regarding advance directives that may include material required in paragraph (d)(1)(i)(A) of this section, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the

HMO or CMP. The same written materials are not required for all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State law concerning advance directives. An HMO or CMP must be able to document its community education efforts.

(2) The HMO or CMP—(i) Is not required to provide care that conflicts with an advance directive.

(ii) Is not required to implement an advance directive if, as a matter of conscience, the HMO or CMP cannot implement an advance directive and State law allows any health care provider or any agent of such provider to conscientiously object.

(3) The HMO or CMP must inform individuals that complaints concerning non-compliance with the advance directive requirements may be filed with the State survey and certification agency.

[58 FR 38072, July 15, 1993, as amended at 59 FR 49843, Sept. 30, 1994; 60 FR 33292, June 27, 1995]

#### **§ 417.440 Entitlement to health care services from an HMO or CMP.**

(a) *Basic rules.* (1) Subject to the conditions and limitations set forth in this subpart, a Medicare enrollee of an HMO or CMP is entitled to receive health care services and supplies directly from, or through arrangements made by, the HMO or CMP as specified in this section and §§ 417.442–417.446.

(2) A Medicare enrollee is also entitled to receive timely and reasonable payment directly (or have payment made on his or her behalf) for services he or she obtained from a provider or supplier outside the HMO or CMP if those services are—

(i) Emergency services or urgently needed services as defined § 417.401;

(ii) Services denied by the HMO or CMP and found (upon appeal under subpart Q of this part) to be services the enrollee was entitled to have furnished by the HMO or CMP.

(b) *Scope of services*—(1) *Part A and Part B services.* Except as specified in paragraphs (c), (d), and (e) of this section, a Medicare enrollee is entitled to

receive from an HMO or CMP all the Medicare-covered services that are available to individuals residing in the HMO's or CMP's geographic area, as follows:

(i) Medicare Part A and Part B services if the enrollee is entitled to benefits under both programs.

(ii) Medicare Part B services if the enrollee is entitled only under that program.

(2) *Supplemental services elected by an enrollee.* (i) Except as provided under paragraph (b)(2)(ii) of this section, a Medicare enrollee of an HMO or CMP may elect to pay for optional services that are offered by the HMO or CMP in addition to the covered Part A and Part B services.

(ii) An HMO or CMP may elect to provide qualified prescription drug coverage (as defined at § 423.104 of this chapter) as an optional supplemental service in accordance with the applicable requirements under part 423 of this chapter, including § 423.104(f)(4) of this chapter.

(iii) The HMO or CMP may not set health status standards for those enrollees whom it accepts for these optional supplemental services.

(3) *Supplemental services imposed by a risk HMO or CMP.* (i) Subject to CMS's approval, a risk HMO or CMP may require Medicare enrollees to accept and pay for services in addition to those covered by Medicare. (ii) If the HMO or CMP elects this option, it must impose the requirement on all Medicare enrollees, without regard to health status. (iii) CMS approves supplemental benefits of this type if CMS determines that imposition of the requirements will not discourage other Medicare beneficiaries from enrolling in the risk HMO or CMP.

(4) *Additional benefits from risk HMOs or CMPs required by statute.* Subject to the conditions stated in § 417.442, a new Medicare enrollee or a current nonrisk Medicare enrollee who converts to risk reimbursement under § 417.444 is eligible to receive, in addition to the covered Part A and Part B benefits for which he or she is eligible, benefits consisting of one or both of the following:

(i) A reduction in the HMO's or CMP's premium rate or in other

charges for services furnished to Medicare enrollees.

(ii) Provision of health benefits or services beyond the required Part A and Part B coverage.

(5) *Special supplemental benefits.* Under conditions described in § 417.444(c), current nonrisk Medicare enrollees who are not converted to the risk portion of the contract, may enroll in a special supplemental plan, if offered by the HMO or CMP, for some or all of the additional benefits described in paragraph (b)(4) of this section.

(c) *Limitation on hospice care—*(1) *Extent of limitation.* (i) *Basic rule.* Except as provided in paragraph (c)(1)(ii) of this section, a Medicare enrollee who elects to receive hospice care under § 418.24 of this chapter waives the right to receive from the HMO or CMP any Medicare services (including services equivalent to hospice care) that are related to the terminal condition for which the enrollee elected hospice care, or to a related condition.

(ii) *Exception.* An enrollee who elects hospice care retains the right to services furnished by his or her attending physician if that physician—

(A) Is an employee or contractor of the HMO or CMP; and

(B) Is not an employee of the designated hospice and does not receive compensation from the hospice for those services.

(2) *Effective date of limitation.* The limitation in paragraph (c)(1) of this section begins on the effective date of the beneficiary's election of hospice care and remains in effect until the earlier of the following:

(i) The effective date of the enrollee's revocation of the election of hospice care as described in § 418.28 of this chapter.

(ii) The date the enrollee exhausts his or her hospice benefits.

(3) *Payment to HMO or CMP.* For the period that the Medicare enrollee's election of hospice care is in effect, CMS pays a cost HMO or CMP only as described in § 417.585.

(d) *Limitation on provision of inpatient hospital services.* If a beneficiary's effective date of coverage, as specified in § 417.450, in a risk HMO or CMP occurs during an inpatient stay in a hospital

paid for under part 412 of this chapter, the HMO or CMP—

(1) Is not responsible for the provision of any of the inpatient hospital services under Part A during the stay and is not required to pay for those services;

(2) Must assume responsibility for payment for or provision of inpatient hospital services under Part A on the day after the day of discharge from the inpatient stay; and

(3) Is responsible for the full scope of services under paragraph (b) of this section, other than inpatient hospital services under Part A, beginning on the effective date of enrollment.

(e) *Extension of provision of inpatient hospital services.* If an enrollee's effective date of disenrollment, as defined by §417.460, occurs during an inpatient stay in a hospital paid for under part 412 of this chapter and the stay is provided or arranged for by the HMO or CMP, or the HMO or CMP is financially responsible for the hospitalization under paragraph (a)(2) of this section, the HMO or CMP—

(1) Is financially responsible for payment of the inpatient services under Part A through the date the beneficiary is discharged from the inpatient stay; and

(2) Is not responsible for the provision of services, furnished on or after the effective date of disenrollment, other than inpatient hospital services under Part A.

(f) *Notice of noncoverage of inpatient hospital care.* (1) If an enrollee is an inpatient of a hospital, entitlement to inpatient hospital care continues until he or she receives notice of noncoverage of that care.

(2) Before giving notice of noncoverage, the HMO or CMP must obtain the concurrence of its affiliated physician responsible for the hospital care of the enrollee, or other physician as authorized by the HMO or CMP.

(3) The HMO or CMP must give the enrollee written notice that includes the following:

(i) The reason why inpatient hospital care is no longer needed.

(ii) The effective date of the enrollee's liability for continued inpatient care.

(iii) The enrollee's appeal rights.

(4) If the HMO or CMP delegates to the hospital the determination of non-coverage of inpatient care, the hospital obtains the concurrence of the HMO- or CMP-affiliated physician responsible for the hospital care of the enrollee, or other physician as authorized by the HMO or CMP, and sends notice, following the procedures set forth in §412.42(c)(3) of this chapter.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 52 FR 8901, Mar. 20, 1987; 58 FR 38079, July 15, 1993; 59 FR 59941, Nov. 21, 1994; 60 FR 45678, Sept. 1, 1995; 70 FR 4525, Jan. 28, 2005]

**§417.442 Risk HMO's and CMP's: Conditions for provision of additional benefits.**

(a) *General rule.* Except as provided in paragraph (b) of this section, a risk HMO or CMP must, during any contract period, provide to its Medicare enrollees the additional benefits described in §417.440(b)(4) if its ACRs (calculated in accordance with §417.594) are less than the average per capita rates that CMS pays for the Medicare enrollees during the contract period.

(b) *Exceptions—(1) Reduced payment election.* An HMO or CMP is not obligated to furnish additional services under paragraph (a) of this section if it has requested a reduction in its monthly payment from CMS under §417.592(e), and it—

(i) Elects to receive reduced payment so that there is no difference between the average of its per capita rates of payment and its ACR; or

(ii) Elects to receive partially reduced payment and furnish Medicare enrollees with additional benefits described in §417.440 (b)(4) so that the combined value of benefits and reduced payment is equivalent to the difference between the average of its per capita rates of payment and its ACR.

(2) *Benefit stabilization fund.* An HMO or CMP may elect to have a part of the value of the additional benefits it must provide under paragraph (a) of this section withheld in a benefit stabilization fund as described in §417.596.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985; 58 FR 38082, July 15, 1993; 60 FR 45678, Sept. 1, 1995]